

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-002814

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 274 Primary Registration District No. 2052 Registrar's No. 39

STATE FILE NUMBER

FILED FEB 4 1963

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia</u>		c. CITY OR TOWN <u>Pilot Grove</u>	
Length of stay in 1b <u>6 weeks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bathwell Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>8 miles west</u>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>MAY</u> Last <u>MUEHLER</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1897</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
11. BIRTH PLACE (City and state or country) <u>Clifton, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Strach</u>		13b. MOTHER'S MAIDEN NAME <u>Allie May</u>	
14. NAME OF HUSBAND OR WIFE <u>Fred Mueller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Margaret Smith, Sedalia, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gangrene lower extremities</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Arteriosclerotic peripheral vascular disease</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Pilot Grove, MO</u>		
21. I attended the deceased from <u>7 Dec 62</u> to <u>28 Jan 63</u> and last saw her alive on <u>24 Jan 63</u> Death occurred at <u>about 7:15 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Carl D. Siegel</u>	
22b. ADDRESS <u>1216 West 18th St, Sedalia, Mo</u>		22c. DATE SIGNED <u>29 Jan 63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 30, 1963</u>	23b. DATE <u>Jan 30, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westley Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Pilot Grove, MO</u>
24. FUNERAL DIRECTOR <u>Hays - Painter, Pilot Grove, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Jan. 30, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Francis Shelby, per N. Anderson</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

6808

6270

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9/53.3

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert L. Painter

Licensed Embalmer No.

4069

P. O. Address

Pilot Grove, mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.